SUMMARY OF BENEFITS

Your CIGNA HealthCare Point-of-Service plan

Features that Add Value

- The reassurance of having a **personal Primary Care Physician (PCP)** who is your source for routine care and guidance when you need more than routine care. As your needs change, so may your choice of doctors. That's why you can change your PCP for any reason.
- The CIGNA HealthCare 24-Hour Health Information Line[SM] connects you **to registered nurses** and a **library** of hundreds of recorded programs on important health topics 24 hours a day, seven days a week, from anywhere in the U.S.
- **CIGNA *Healthy Rewards*[®]** includes special offers on health and wellness programs and services often not covered by traditional benefits plans. Just call 1.800.870.3470 or visit our web site at www.cigna.com.
- Prescription drug coverage is a **part of your plan**. More than 50,000 pharmacies participate nationwide, so you can have your prescription filled **wherever you go**. Mail-order service means quick, **convenient** delivery of your medications right to your home.
- Our Guest Privileges program **brings** your CIGNA HealthCare **benefits along** when you temporarily relocate or send kids to schools away from home. Call CIGNA HealthCare Member Services to learn more.
- CIGNA Behavioral Health offers you access to **professional consultation** over the phone to **help you** with problems that affect you, your family, or your work.

Quality Service Is Part of Quality Care

- **Service** is at the heart of everything we do. Our goal is to give you: fast, accurate answers; responsive, courteous and professional assistance; and ease and convenience in finding the information you need to manage your health.
- **www.cigna.com** – Visit our **interactive Web site** to learn more about your plan and get health information, 24 hours a day.
- **We Speak Many Languages[SM]**. We offer the Language Line Services so that you can **talk with us** in 140 different languages. Just call Member Services, and ask for an interpreter to assist you.

It's Your Health

When you choose CIGNA HealthCare, you can take advantage of our **health and wellness** programs:

- **Preventive care services** for every covered family member.
- See a participating OB/GYN – **no referral** required.
- CIGNA Well Aware for Better Health[SM] can **help you manage** certain chronic conditions.
- The CIGNA HealthCare Healthy Babies[®] program provides you with education and support to help you have a **healthy pregnancy** and **a healthy baby.** And there's no copayment for prenatal care office visits after the first visit that confirms you're pregnant.

You Can Depend on CIGNA HealthCare

- **Quality comes first**. We select participating providers carefully. And we make sure you have a **wide range** of PCPs and specialists to choose from.
- **Emergency and urgent care are covered** wherever you go, worldwide, **24 hours a day**. Urgent care centers can take care of your urgent care needs, and you pay a lower copayment.

It's Your Choice

- When your PCP coordinates your care and you visit network providers, you get access to quality care at the lowest out-of-pocket costs available under your plan. You also get the **freedom to choose** the providers you prefer — even if they aren't part of the network. Your costs are lowest when you see participating providers, but you're still covered for visits to other providers.

For Employees of Loudoun County - Volunteer Firefighters

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Physician Services		
Primary Care Physician (PCP) Office Visit	$10 copayment per office visit; No charge if only x-ray and/or lab services performed and billed.	10% of charges*
Specialty Physician Office Visit	$15 copayment per office visit; No charge if only x-ray and/or lab services performed and billed.	10% of charges*
Consultant and Referral Physician Services		
Allergy Treatment/Injections - PCP or Specialty Physician	$10 or $15 copayment per office visit or actual charge, whichever is less	10% of charges*
Allergy Serum (dispensed by physician in office)	No charge	10% of charges*
Second Opinion Consultations (provided on voluntary basis)	$10 or $15 copayment per office visit	10% of charges*
Surgery Performed in the Physician's Office- PCP or Specialty Physician	$10 or $15 copayment per office visit	10% of charges*
Preventive Care		
Routine Preventive Care – Well Baby, Well Child Care, Adult Care and Well Woman (including immunizations)	$10 or $15 copayment per office visit; No charge if only x-ray and/or lab services performed and billed.	10% of charges*
***Note**: Well Woman OB/GYN visits are subject to the specialty physician's office visit copay.*		
Immunizations birth through age 2	No charge	10% of charges*
Routine Immunizations and Injections age 3 and above	The office visit copayment will be waived when immunization is the only service provided.	10% of charges*
Mammograms, PSA, Pap Test	No charge	10% of charges*
(Preventive Care Related Routine Services)	***Note***: $10 or $15 copayment per office visit for the associated wellness exam	***Note***: the associated wellness exam is not covered
(***Note**: Diagnostic Related Services are subject to the plan's laboratory & radiology benefit; based on place of service)*		
***Inpatient Hospital Services including**:*	No charge	10% of charges*
Semi-Private Room and Board		
Diagnostic/Therapeutic Lab and X-ray		Precertification required
Drugs and Medication		
Operating and Recovery Room		
Radiation Therapy and Chemotherapy		
Anesthesia and Inhalation Therapy		
Inpatient Hospital Doctor's Visits/Consultations	No charge	10% of charges*
Inpatient Hospital Professional Services	No charge	10% of charges*
Outpatient Facility Services	No charge	10% of charges*
Operating Room, Recovery Room, Procedure Room, Treatment Room and Observation Room including:		
Diagnostic/Therapeutic Lab and X-rays		
Anesthesia and Inhalation Therapy		
Physician and Outpatient Professional Services	No charge	10% of charges*
Laboratory and Radiology Services		
(includes preadmission testing)		
Advanced Radiological Imaging	No charge	10% of charges*
(MRIs, CAT Scans, PET Scans, etc.)		
Other Laboratory and Radiology Services		
Physician's Office	No charge	10% of charges*
Outpatient Hospital Facility	No charge for facility charges; No charge for outpatient professional charges	10% of charges*
Emergency Room Facility (billed by facility as part of the Emergency Room visit)	No charge	10% of charges*
Independent X-Ray and/or Lab Facility	No charge	10% of charges*
Independent X-Ray and/or Lab Facility (in conjunction with an Emergency Room visit)	No charge (If ER visit is considered to be a true emergency)	No charge (If ER visit is considered to be a true emergency)
Inpatient Services at Other Health Care Facilities	No charge	10% of charges*
Skilled Nursing, Rehabilitation and Sub-Acute Facilities		Precertification required.
60 days maximum per contract year for all facilities listed#		

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Short-Term Rehabilitative Therapy and Chiropractic Services-(includes cardiac rehab, physical, speech, occupational, chiropractic, pulmonary rehab & cognitive therapy) - 20 visits maximum per contract year# for all therapies combined	$20 copayment per office visit; No charge if only x-ray and/or lab services performed and billed.	10% of charges*
Early Intervention Services birth to age 3 $5,000 maximum benefit per person per calendar year#	$10 or $15 copayment per office visit; No charge if only x-ray and/or lab services performed and billed.	10% of charges*
Emergency and Urgent Care Services *Physician's Office-PCP or Specialty Physician*	$10 or $15 copayment per office visit; No charge if only x-ray and/or lab services performed and billed.	$10 or $15 copayment per office visit; No charge if only x-ray and/or lab services performed and billed.
Hospital Emergency Room	$50 copayment per visit *(copay waived if admitted*)	$50 copayment per visit *(copay waived if admitted*)
Outpatient Professional Services (Radiology, Pathology and Emergency Room Physician)	No charge	No charge
Urgent Care Facility or Outpatient Facility	$25 copayment per visit *(copay waived if admitted*)	$25 copayment per visit *(copay waived if admitted*)
Ambulance	No charge	No charge
	Note: if not a true emergency, services are not covered	*Note: if not a true emergency, services are not covered*
Maternity Care Services *Initial Office Visit to Confirm Pregnancy*	$10 or $15 copayment for initial office visit	10% of charges*
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (total maternity fee)	No charge	10% of charges*
Office Visits not included in the total maternity fee performed by OB or Specialty Physician	$15 copayment per office visit; No charge if only x-ray and/or lab services performed and billed	10% of charges*
Delivery - Facility (Inpatient Hospital/Birthing Center Charges)	No charge	10% of charges*, Precertification required
Home Health Services*-Includes outpatient private duty nursing when approved as medically necessary.* 60 days maximum per contract year# 16 hour maximum per day#	No charge	10% of charges*
Family Planning Services *Office Visits (tests, counseling)- PCP or Specialty Physician*	$10 or $15 copayment per office visit; No charge if only x-ray and/or lab services performed and billed.	10% of charges*
Vasectomy/Tubal Ligation *(excludes reversals)*		
Inpatient Facility	No charge	10% of charges*, Precertification required
Outpatient Facility	No charge	10% of charges*
Physician's Services – Inpatient or Outpatient	No charge	10% of charges*
Physician's Office	$10 or $15 copayment per office visit	10% of charges*
Infertility Services *Office Visit (lab & radiology tests, counseling) – PCP or Specialty Physician*	$10 or $15 copayment per office visit; No charge if only x-ray and/or lab services performed and billed	10% of charges*
Treatment/Surgery (includes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc.)		
Inpatient Facility	No charge	10% of charges*, Precertification required
Outpatient Facility	No charge	10% of charges*
Physician's Services	No charge	10% of charges*
$20,000 Lifetime maximum per member#		
TMJ - Surgical and Non-Surgical-case-by-case basis. Always excludes appliances and orthodontic treatment. Subject to medical necessity.		
Office Visit	$10 or $15 copayment per office visit; No charge if only x-ray and/or lab services performed and billed.	10% of charges*
Inpatient Facility	No charge	10% of charges*, Precertification required
Outpatient Facility	No charge	10% of charges*
Physician's Services	No charge	10% of charges*

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Mental Health Services (Biologically based Mental Illness, including alcoholism and drug addiction)		
Inpatient	No charge	10% of charges*, Precertification required
Outpatient	$15 copayment per office visit	10% of charges*
Mental Health and Substance Abuse (Combined)		
Inpatient - 30 days maximum per contract year#	No charge	10% of charges*, Precertification required
Acute*:* Based on a ratio of 1:1		
Partial*:* Based on a ratio of 2:1		
Residential*:* Based on a ratio of 2:1		
Substance Abuse:		
Acute Detox**:** Based on a ratio of 1:1 ***(requires 24 hour nursing)***		
Acute Inpatient Rehab*:* Based on a ratio of 1:1 (requires 24 hour nursing)		
Partial: Based on a ratio of 2:1		
Residential*:* Based on a ratio of 2:1		
Outpatient Individual– 20 visits maximum per contract year#	$15 copayment per office visit	10% of charges, no deductible
Group Therapy – Mental Health – combined maximum with Outpatient Individual Mental Health services based on a ratio of 1:1	$15 copayment per session	10% of charges, no deductible
Intensive Outpatient Mental Health& Substance Abuse Services – 3 programs maximum per contract year based on a ratio of 1:1 with outpatient Mental Health and Substance Abuse visits	$50 copayment per program, plus 50% of charges	$50 deductible per program, plus 50% of charges
Durable Medical Equipment	No charge $3,500 maximum per contract year	10% of charges* $700 maximum per contract year
External Prosthetic Appliances	$200 EPA deductible $1,000 maximum per contract year	$200 EPA deductible plus 10% of charges* $1,000 maximum per contract year#
Prescription Drugs		
CIGNA Pharmacy Plus Retail Drug Program	$7 per 30-day supply for generic drugs	Covered in-network only
Includes oral contraceptives and contraceptive devices, oral fertility drugs	$15 per 30-day supply for preferred brand-name drugs	Covered in-network only
	$35 per 30-day supply for non-preferred brand-name drugs	Covered in-network only
CIGNA Tel-Drug Mail Order Drug Program	$14 per 90-day supply for generic drugs	Covered in-network only
	$30 per 90-day supply for preferred brand name drugs	Covered in-network only
	$70 per 90-day supply for non-preferred brand-name drugs	Covered in-network only

OTHER BENEFIT INFORMATION	IN-NETWORK	OUT-OF-NETWORK
Contract Year Plan Deductible *Individual / Family*	None / None	$200 / $600
Contract Year Out-of-Pocket (OOP) Maximum *Individual / Family*	$1,500 / $3,000	Includes member paid coinsurance,. Excludes plan deductible $1,500 / $3,000
Coinsurance	CIGNA HealthCare pays 100% of eligible charges. You pay 0% of charges.	CIGNA HealthCare pays 90% of eligible charges. You pay 10% of charges after plan deductible.
Precertification -Inpatient – PHS+ (required for all inpatient admissions)	Coordinated by your physician	Participant must obtain approval for inpatient admission; subject to penalty/reduction or denial for non-compliance
Precertification – Outpatient – PHS+ (required for selected outpatient procedures and diagnostic testing or outpatient services)	Coordinated by your physician	Participant must obtain approval for selected outpatient procedures and diagnostic testing; subject to penalty/reduction or denial for non-compliance.
Lifetime Maximum	Unlimited#	$1,000,000#
Pre-existing Condition Limitation	No	Yes

**** Out-of-network services are subject to the contract year deductible and reasonable and customary charge limitations.***

 # Day, visit or dollar maximums apply to In-Network and Out-of-Network services combined.

Footnotes:

Regarding In-Network Services:

- *Only Inpatient and Outpatient Facility copayments and coinsurance apply to the out-of-pocket maximum. The copayments/coinsurance are no longer required once the out-of-pocket maximum is reached.*

Regarding Out-of-Network Services:

- *The Out-of-Network Inpatient & Outpatient Facility deductibles and coinsurance apply to the Out-of-Network out-of-pocket maximum.*
- *All out-of-network hospital admissions and certain outpatient surgical and diagnostic procedures must be precertified and are subject to Continued Stay Review (CSR). A penalty applies to admissions which are not precertified. Non-approved admissions/days result in denial of benefits. The precertification penalty or cost of denied benefits does not apply to deductible or out-of-pocket maximum.*
- *Once the out-of-pocket maximum for Out-of-Network is reached, the plan pays 100% of eligible charges for the remainder of the plan year.*
- *Coverage for pre-existing conditions will not be covered under this plan unless continuously insured for one year.*

Mental Health

All inpatient Mental Health and Substance Abuse benefits are authorized by CIGNA Behavioral Health, Inc., or its affiliates.

Benefit Exclusions.

These are examples of the exclusions in your plan. The complete list of exclusions is provided in your Certificate or Summary Plan Description. To the extent there may be differences, the terms of the Certificate or Summary Plan Description control.

1. Any service or supply not described as covered in the Covered Expenses section of the plan.
2. Any medical service or device that is not medically necessary.
3. Treatment of an illness or injury which is due to war or care for military service disabilities treatable through governmental services.
4. Any services and supplies for or in connection with experimental, investigational or unproven services.
5. Dental treatment of the teeth, gums or structures directly supporting the teeth, however, charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within 6 months of the accident.
6. Medical and surgical services, initial and repeat, intended for the treatment or control of obesity, including clinically severe (morbid) obesity, including: medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.
7. Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons, including but not limited to employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.
8. Court ordered treatment or hospitalizations
9. Infertility donor services and charges.
10. Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction.
11. Medical and hospital care and costs for the child of a Dependent, unless this infant child is otherwise eligible under the plan.
12. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance.
13. Consumable medical supplies other than ostomy supplies and urinary catheters.
14. Private hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
15. Artificial aids, including but not limited to hearing aids, semi-implantable hearing devices, audiant bone conductors, bone anchored hearing aids, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
16. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery).
17. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
18. Non-prescription drugs and investigational and experimental drugs, except as provided in the plan.
19. Routine foot care, however, services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.
20. Genetic screening or pre-implantation genetic screening.
21. Fees associated with the collection or donation of blood or blood products.
22. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
23. All nutritional supplements and formulae are excluded, except infant formula needed for the treatment of inborn errors of metabolism.
24. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
25. Expenses incurred for medical treatment by a person age 65 or older, who is covered under the plan as a retiree, or his dependent, when payment is denied by the Medicare plan because treatment was not received from a participating provider of the Medicare plan.
26. Expenses incurred for medical treatment when payment is denied by the primary plan because treatment was not received from a participating provider of the primary plan.

Benefit Exclusions – continued:

27. The following services are excluded from coverage regardless of clinical indications: Massage Therapy; Cosmetic Surgery and Therapies; Macromastia or Gynecomastia Surgeries; Surgical Treatment of Varicose Veins; Abdominoplasty/Panniculectomy; Rhinoplasty; Blepharoplasty; Orthognathic Surgeries; Redundant Skin Surgery; Removal of Skin Tags; Acupressure; Craniosacral/cranial therapy; Dance Therapy, Movement Therapy; Applied Kinesiology; Rolfing; Prolotherapy; Transsexual Surgery; Non-medical counseling or ancillary services; Assistance in the activities of daily living; Cosmetics; Personal or Comfort Items; Dietary Supplements; Health and Beauty Aids; Aids or devices that assist with non-verbal communications; Treatment by Acupuncture; Dental implants for any condition; Telephone Consultations; E-mail & Internet Consultations; Telemedicine; Health Club Membership fees; Weight Loss Program fees; Smoking Cessation Program fees; Reversal of male and female voluntary sterilization procedures; and Extracorporeal Shock Wave Lithotripsy for musculoskeletal and orthopedic conditions.

These Are Only the Highlights

As you can see, the plan is designed to combine in-depth coverage with cost-effective prices. This summary contains highlights only and is subject to change. The specific terms of coverage, exclusions and limitations including legislated benefits are contained in the Summary Plan Description or Insurance Certificate. This plan is insured and/or administered by Connecticut General Life Insurance Company, a CIGNA Company.

"CIGNA HealthCare" refers to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, Tel-Drug, Inc. and its affiliates, CIGNA Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc.